

CHAPTER 4: PROVIDER RESPONSIBILITIES AND GUIDELINES

UNIT 7: MEDICAL RECORDS DOCUMENTATION REQUIREMENTS

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[What Is My Service Area?](#)

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only: **Where no symbol is present, the information is relevant to all states.**



The **PA ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The **DE ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The **WV ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

4.7 MEDICAL RECORDS OVERVIEW

Introduction

Highmark makes every effort to provide resources to assist providers in servicing our members and working with us. This unit of the manual was developed to provide guidelines for documenting members' medical records that will help you to have the appropriate documentation readily available for medical necessity reviews. This will help us to ensure accuracy of billed claims data and, therefore, prevent delays in reviews and payment.

The content herein provides minimum standards for medical record detail necessary to document and support claims for services rendered to members. It is the provider's responsibility to adhere to professional standards, as well as applicable laws, regulations, and directives, with respect to medical recordkeeping and when such obligations are not addressed in this Unit.

Please note that examples included within this Unit are general in nature.

Purpose of a medical record

A medical record must clearly document the medical care provided to a member. Medical record documentation is necessary to record applicable observations and findings regarding the member's history, examinations, diagnostic tests and procedures, diagnoses, treatments and treatment plan, necessary follow-up care, and outcomes or responses to care per date of service or encounter.

Additionally, the medical record serves as a formal document and a communication tool between providers, vendors, and Highmark. All medical documentation must be maintained in the member's medical record and, if requested, made available to Highmark or its contracted vendor by the requested date.

Benefit application

Coverage guidelines are determined according to individual or group customer benefits. All services reported for Highmark members must be supported within the medical record and all claims may be subject to medical review.

You should not routinely submit this documentation with your claims, except in circumstances when required. However, if requested, medical documentation must be made available to Highmark or its contracted vendor.

The medical record is expected to include such information as noted above and defined in the provider requirements within this Unit. Reimbursement may be denied for services that are not clearly documented within the member's medical record.

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4.7 MEDICAL RECORDS OVERVIEW, Continued

Medical record retention

Providers are required to retain all records, including medical records, in accordance with the provider's participation agreements and Highmark's administrative requirements, as well as all applicable state and federal laws, Regulations, and governmental program requirements.

REMINDER: Refer members to network participating providers

Highmark contracted providers are strongly encouraged to refer members to providers participating in the member's network. This protects the member from higher costs that may be incurred if services are received from a non-network provider.

If an out-of-network referral is necessary, the reason for the referral to an out-of-network provider must be documented in the member's medical records.

FOR MORE INFORMATION

Please refer to Highmark's Medical Policies and Reimbursement Policies for additional information. These can be accessed by selecting **CLAIMS, PAYMENT AND REIMBURSEMENT** from the left menu on the Provider Resource Center.

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4.7 ELECTRONIC HEALTH RECORDS

Introduction

Electronic health records (EHRs) can help providers better manage care by enabling quick access to accurate, up-to-date, and complete information about their patients at the point of care. They also promote complete and legible documentation to improve productivity and efficiency in coding and billing.

Cloning and copying forward not permitted

Providers must ensure that every entry is accurate and unique to the individual member. Functions such as cloning, copy and paste, cookie cutter, copy forward, and carrying forward are similar in that using these features has the potential to create inaccuracies in documentation by using the same language from member to member.

Highmark strongly discourages cloning and copying forward because utilization of canned statements within the EHR may not reflect accurate clinical determinations if not reviewed carefully, as they may lead to the following issues:

- Potential for a false description of services rendered to the member
- Potential for medical errors by using outdated or inaccurate information
- Coding from old or outdated information may result in inaccurate coding

Inconsistencies as a result of cloning, copying, or pasting found during the review of a member's medical record may result in denial of the claim.

Authenticate records

Providers must authenticate records that have been written by others, especially when another individual (such as a scribe) types the documentation into the EHR. Errors may not be identified when the responsible providers signs the record without reading the content thoroughly.

Use of addenda

Delayed entries within reasonable time frames may be appropriate for clarification, error correction, or for the addition of information not available at the time of the initial entry.

However, addenda are not to be used to add services reported at the time of the initial service or to retrospectively add information to justify medical necessity. In addition, using addenda to enhance documentation can cause medical records to be altered inappropriately.

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4.7 ELECTRONIC HEALTH RECORDS, Continued

Amending the medical record If it is necessary to amend a medical record, the **original documentation should not be deleted**. Retain and clearly identify all original content.

Any edits to the medical record must be clearly and permanently identified as such – as an amendment, delayed entry, or correction.

- Document whether the edit is an amendment, delayed entry, or correction.
 - Indicate the date and author of all changes, corrections, and delayed entries.
-

Signatures Legible dates, times, signatures, and credentials are required from each person (physicians, scribes, residents, nurses, etc.) who updates, reviews, and/or approves the medical record. Signatures are also required for the addition of any other pertinent information to ensure the validity of the data.

In addition, signatures must include the credentials of the performing provider. Hard copy records must be signed (electronic signature is also acceptable) on each page by the person providing the service.

Audits For audit purposes, ensure all required documentation is sent in by the request date and ensure the EHR software is identified.

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4.7 DOCUMENTATION REQUIREMENTS FOR ALL PROVIDERS

Introduction All providers are required to comply with the following requirements and include the information below, as applicable, in a member's medical records in order to support a claim for reimbursement of services.

Failure to comply with the requirements and provide the requested information may result in a denial of authorization or reimbursement for services.

Confidentiality Medical records must be stored and maintained to fully protect the confidentiality, integrity, and safety of the member's information.

Medical record organization Sections within the medical record must be organized in a consistent manner.

- All entries are legible.
- All entries are dated and timed.
- All entries must be signed or initialed by the author, with his/her title, credentials, and specialty.
- Member identifiers must be included on every page of documentation.
- All member encounters, including telephone, fax, and electronic message exchanges, are documented.

Medical history The initial physical examination and the member's medical history are to be recorded at the initial visit for new members. For members younger than six (6) years old, medical record birth history must be included in the child's medical records.

Prior medical history is documented to include any serious accidents, operations, and illnesses. In addition, family medical history is to be included in the medical record.

Medications, allergies, and problems The following must be documented prominently in the member's medical record and updated as necessary:

- Medications currently taken and all newly prescribed medications
- Allergies and/or adverse reactions; or display "None" or "NKA" if no allergies are known
- Current and updated problem list

FDA label restrictions Medical records must include documentation of weight and date of birth for prescribed medications as required by the Food and Drug Administration (FDA).

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4.7 DOCUMENTATION REQUIREMENTS FOR ALL PROVIDERS,

Continued

Member encounters

For all member encounters, including telephone, fax, and electronic message exchanges, ensure that the following are clearly documented:

- Member's chief complaint or purpose for each visit/encounter
 - Clinical assessment and/or physical findings (ensure working diagnoses are consistent with these findings)
 - Treatment plans and goals (ensure treatment plans are consistent with the recorded diagnosis(es) code)
 - Any unresolved problems from prior visits are addressed
 - Follow-up instructions and necessary follow-up appointments
-

Treatment options

All treatment options, conservative or alternative, are to be documented in the member's medical record as required by Highmark Medical Policies.

Coordination of care

Primary care physicians and specialists, including medical, surgical, and behavioral health, must communicate with one another. The exchange of information in an effective, timely, and confidential manner promotes appropriate diagnosis and treatment.

The coordination of care between primary care and specialty care providers or other practitioners is to be documented within the member's medical record.

Diagnostic testing and results

When services are provided by an external provider (e.g., radiologists, labs, referrals, consultations), the documentation they provide, including follow-up letters, are to be included in the member's medical record.

Laboratory and diagnostic testing results must be signed by the practitioner to acknowledge that they have been reviewed. Review of diagnostic services must include the CPT codes of the diagnostic test(s) reviewed.

In addition, the documentation must confirm that the member was notified of diagnostic testing/laboratory results and the practitioner's follow-up recommendations.

Time-based codes

Start and stop times and total time must be documented within the medical record when time is a required factor for reporting services.

Examples include, but are not limited to: anesthesia services, physical medicine services, screening services, prolonged services, observation services, critical care, discharge day, etc.

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4.7 DOCUMENTATION REQUIREMENTS FOR ALL PROVIDERS,

Continued

NOC CPT/HCPCS codes

When a Not Otherwise Classified (NOC) CPT or HCPCS code is billed:

- The service provided cannot have an exclusive CPT or HCPCS code, which defines the service rendered.
 - A detailed description of the service or item provided must be included within the medical record.
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All codes on claim must be substantiated

All CPT, HCPCS, and ICD-10 codes reported on the claim must be substantiated within the member's medical record.

Amending the medical record

If it is necessary to amend a medical record, the **original documentation should not be deleted**. Retain and clearly identify all original content.

Any edits to the medical record must be clearly and permanently identified as such – as an amendment, delayed entry, or correction.

- Document whether the edit is an amendment, delayed entry, or correction.
 - Indicate the date and author of all changes, corrections, and delayed entries.
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4.7 ADDITIONAL REQUIREMENTS TO SUPPORT E/M SERVICES

Coding guidelines for E/M services

Based on Current Procedure Terminology (CPT) coding guidelines, either the 1995 or 1997 Centers for Medicare & Medicaid Services (CMS) Documentation Guidelines are to be used when documenting evaluation and management (E/M) services in the medical record.

All services performed and the diagnosis(es) related to the visit must be documented in the member's medical record.

Separately billed E/M services

Separately billed E/M services following a procedure within a global surgical period must be supported in the member's medical record.

Criteria that must be documented

To ensure accuracy of diagnosis coding, the following criteria, as applicable to the visit, must be documented in the medical record:

- Laterality (left vs. right)
- Specific location of injury, pain, or disease
- Condition status (acute, chronic, chronic intractable, recurrent, controlled, uncontrolled, etc.)
- Date of occurrence of injury or symptoms
- Fracture type (e.g., open or closed, displaced or non-displaced)
- Stage of condition (e.g., decubitus ulcer stage)
- Weeks/trimester of pregnancy
- Congenital conditions
- Illness phase (e.g., dysphagia, pharyngeal phase)
- Encounter status (initial, subsequent, sequela)

This list is not an all-inclusive list; additional criteria may be necessary based on the reason for the visit.

4.7 HOSPITAL/FACILITY SERVICES

Introduction	This section provides medical records documentation guidelines for services provided to members at a hospital or other facility as an inpatient, outpatient, or for emergency department care.
Hospital medical record	<p>Documentation in the member's hospital medical record for inpatient, outpatient, and emergency department visits must include the intake of the member's history and physicals performed at the time of admission or visit.</p> <p>The medical record should also include, but is not limited to, the following as applicable:</p> <ul style="list-style-type: none"> • Physician orders • Provider's progress notes • Consultative physician notes and records • Laboratory and diagnostic imaging • Medications ordered and administered • Immunization records • Diagnosis codes consistent with laboratory or diagnostic services • Critical or preventable serious adverse events (PSAE) • Documentation of restraint usage • Risk of treatment outcomes • Member responsibility of services (e.g., Notice of Denial of Medical Coverage) • Authorization requests such as, but not limited to, NaviNet® with information to justify admission • Referrals to other providers • Reason(s) why a service was discontinued or not started
Attending physician's progress notes	Countersignatures by the attending physician of another physician's orders or notes are not acceptable documentation of the attending physician's services. A countersignature must be supplemented by the attending physician's own progress notes.
Visit on day of discharge	When a claim for a hospital visit is billed on the same day as discharge, inpatient progress notes must support the reason for the visit.

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4.7 HOSPITAL/FACILITY SERVICES, Continued

Discharge summary

The hospital discharge summary must contain the following:

- Reason for hospitalization
- Significant findings
- Procedures
- Treatments provided
- Member discharge condition
- Discharge orders
- Member education
- Discharge planning notes, including all options and/or facilities discussed with member and/or caregivers
- A written plan of care that is multi-disciplinary and is updated throughout continuum of care

Acute care transfers

If an acute care transfer, the rationale for the transfer must include:

- Name of facility/hospital
- Arrangements to facilitate transfer
- MD orders and updates for actual services rendered with time and dates for all inpatient and/or observation stays
- A written plan of care that is multi-disciplinary and updated throughout the continuum of care

Post-acute provider referrals

Documentation for post-acute provider referrals must include MD orders and updates for actual services rendered. The MD's orders must include time and dates for all inpatient and/or observation stays.

In addition, a written multi-disciplinary plan of care must be included and updated throughout the continuum of care.

Consultations

Requests for consultations must be documented within the member's medical record. Consultations must be ordered and documented by the attending physician.

The consultation reports must be dictated and typed or hand-written, and they must contain the signature of the physician who performed and reported the consultation.

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4.7 HOSPITAL/FACILITY SERVICES, Continued

Services rendered by hospital interns and residents

Services rendered by interns, residents, or any other hospital/facility employee under the supervision of the attending physician may be reported by the attending physician. The care must be documented and signed by the attending physician in the progress notes, or other pertinent records, reflecting the level of medically necessary care.

Surgical procedures

The medical record must contain all relevant information related to performing the surgical procedure, including but not limited to:

- Pre- and post-operative diagnosis(es) codes
- Implant/device make and model numbers
- Comprehensive list of procedure(s) performed
- Any techniques used to perform the procedure(s)

The performing physician's name and all assistants' names are to be recorded in the operative report. When a procedure(s) requires the services of two surgeons or a surgical team, documentation must clearly establish that each surgeon performed distinct and separate components in a team fashion.

The operative report must indicate the name of the anesthesiologist(s), certified registered nurse anesthetist(s) (CRNAs), and/or anesthetists who performed the anesthesia services.

Please refer to Highmark's medical policies and reimbursement policies for more information. Highmark **Medical Policy** and **Reimbursement Policy** are both available on the Provider Resource Center under **CLAIMS, PAYMENT & REIMBURSEMENT**.

Global obstetrical/surgical care

When a global service is reported, all pre- and post-operative/obstetrical care must be recorded in the member's medical record.

Minor surgical procedures can be described in the progress/office notes and must be signed by the provider reporting the service.

Evidence of conservative measures taken should be noted, if applicable.

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4.7 HOSPITAL/FACILITY SERVICES, Continued

Anesthesia

The operative and anesthesia reports both must indicate the name of the anesthesiologist(s), CRNA(s), and/or anesthesiologists who performed the anesthesia services.

Start and stop times and number of units provided must be clearly documented.

Pre- and post-operative evaluations or other encounters with the member must be documented in the medical record. This is important when monitoring members who are in active labor or who post-operatively require additional anesthesia services.

When an anesthesiologist is supervising one or more anesthesiologists, the supervising physician's presence and interventions must be recorded on the anesthesia record.

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4.7 ANCILLARY SERVICES

Ambulance

When transporting a Highmark member by ambulance, the following information must be documented and maintained in the member's medical records:

- Member identifying information (name, Member ID, address)
- Date of service
- Point of origin/destination
- Total mileage
- Beneficiary or authorized representative signature
- Records from hospital/facility noting need for ambulance and medical necessity of transport
- Legible documentation signed by the primary attendant which includes, but is not limited to, a detailed trip sheet

If the member was transported beyond the closest facility, the reason for doing so must be contained in the medical record. In addition, the reason for transport by air ambulance instead of ground ambulance must be documented.

For additional information about ambulance services, please see Highmark Medical Policy. Medical Policy can be accessed on the Provider Resource Center by selecting **CLAIMS, PAYMENT & REIMBURSEMENT**.

Diagnostic X-rays and/or X-ray reports

Relevant and/or current records from the prescribing physician's office (e.g., office notes, history and physical, labs, etc.) can serve as supporting documentation of medical necessity for the service provided by a radiology provider.

The radiology provider must also document the following in the member's medical record:

- Member name, Member ID, date of service
- Name of provider performing and interpreting the study
- Clear directional markers
- Specific description and diagnosis of X-ray findings
- Radiology reports for all services billed
- Overall treatment plan

When billing for travel allowance, documentation pertaining to travel expenses should also be included.

Dialysis

For dialysis services, the member's medical record should include the member's name, Member ID, and the date of service.

In addition, the records should include the following:

- Dialysis Flow Sheets
 - Medication Record(s)
-

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4.7 ANCILLARY SERVICES, Continued

Hospice

For hospice care, the documentation must include the following:

- The date the plan of care is established, which must occur prior to the member beginning hospice
 - The date the hospice plan is initiated
-

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4.7 PSYCHIATRIC CARE, PSYCHOTHERAPY, AND COUNSELING

Introduction When psychiatric care, psychotherapy, and counseling services are provided, medical records documentation must include the requirements identified below.

Note: Psychotherapy notes should not be included in the medical records.

Date of service and provider information The date of service must appear prominently within the member's medical record. The documentation must include the identity and legible signature of the person administering the service on that date. The provider's certification(s) must also be documented. If applicable, the referral source must be indicated.

History The member's psychiatric hospitalizations and associated diagnosis(es) must be included in the medical records along with the treatment obtained and the results of each hospitalization.

In addition, a family psychiatric history, including any hospitalizations and associated diagnosis(es) codes, should also be included. Family history should also include successes with specific medications.

Observations and type of therapy Observations of the member during the intake should be noted in the medical records. The type of therapy must be contained in the medical records for each session, along with content of the session and the therapeutic techniques and approaches used.

For interactive therapy, the member record must indicate the adaptations utilized in the session and the rationale for using a specific technique.

In addition, an assessment of the member's ability to adhere to the treatment plan, as well as any treatment failures, should also be documented.

The time spent during an encounter with the member, informant, and/or the family must be legibly documented in the member's medical records. Also, start/stop times must be documented within the medical records for all time-based codes.

Diagnoses The diagnosis(es) must be clearly documented and the clinical presentation, which supports the diagnosis, noted.

Documentation supporting a multiaxial diagnosis must be included, if applicable.

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4.7 PSYCHIATRIC CARE, PSYCHOTHERAPY, AND COUNSELING,

Continued

Medications

Any medications that the member is currently taking and all newly prescribed medications must be documented.

If there are any changes in medications or an adjustment in dosage of a medication already prescribed, the rationale for the change or adjustment needs to be clearly documented.

Progress and follow-up

Note(s) indicating the member's status and/or progress must be contained within the medical records documentation. In addition, follow-up instructions provided during the encounter must be included.

When E/M is provided

When evaluation and management (E/M) is provided:

- Providers are to clearly separate and document the time spent for the E/M service and time spent for psychiatric, psychotherapy, and/or counseling services.
- E/M documentation guidelines apply as outlined in the E/M section of this Unit.
- The psychotherapy service must be "significant and separately identifiable."

When psychotherapy is performed in addition to an E/M, the level of the E/M chosen must reflect the work performed and not the amount of time spent providing counseling and coordination of care.

4.7 OPIOID ADDICTION MANAGEMENT

Controlled substance programs

Prior to dispensation of a controlled substance, dispensing providers are required to enroll or query the member in a controlled substance program for their respective service area. The enrollment must be documented in the member's medical record.

Click on the appropriate link below to access the log in page for the program for the member's service area:

- **PENNSYLVANIA:** Prescription Drug Monitoring Program (PDMP) at: <https://pennsylvania.pmpaware.net/login>
- **WEST VIRGINIA:** Controlled Substance Automated Prescription Program (CSAPP) at: <https://www.csappwv.com/Account/Login.aspx?ReturnUrl=%2f>
- **DELAWARE:** Delaware Prescription Monitoring Program (DPMP) at: <https://dpr.delaware.gov/boards/pmp/>

[What Is My Service Area?](#)

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4.7 DIAGNOSTIC AND THERAPEUTIC TESTING

Overview When tests are performed, all reasons for the testing as well as test results/findings must be documented in the member record and signed by the ordering physician. This applies to laboratory, pathology, radiology, cardiology, and other ancillary or machine testing services.

Medical record documentation All diagnostic and therapeutic services for which a member was referred by a practitioner must be maintained in the member's medical record records. This includes, but is not limited to:

- Home health nursing reports
- Specialty physician reports
- Hospital discharge reports
- Physical therapy reports
- All computer-generated test data results

For diagnostic testing, including laboratory and radiology, the ordering provider must maintain a copy of the request as part of the member's permanent medical record. Additionally, the performing provider must also have a copy of the request on file in the member's medical records.

Highmark does not permit standing orders for diagnostic testing.

Testing interpretation When a testing interpretation code is used, the medical record must contain a documented report signed by the physician who reported the service.

Travel expenses Travel expenses may be billed for some diagnostic services. Documentation pertaining to all travel expenses must be included in the member's medical records.

4.7 THERAPY SERVICES

Introduction This section provides medical records documentation guidelines for therapy services, including: physical therapy; occupational therapy; speech therapy; chiropractic care; and acupuncture.

Requirements The following items must be documented within the member's medical record when treatment, manipulation, or therapy is provided:

- Member name
- Member ID number
- Date of service
- Member's complaint
- Diagnostic studies and results
- Results of previous treatments
- Planned treatments and/or diagnostic studies

A clear description of the type of treatment provided, including the body region(s) treated, must be included in the documentation. In addition, an assessment or physical findings to support the therapeutic treatment or manipulation provided must also be included.

Associated updates to the treatment plan based on changes in the member's condition must be noted. The medical records documentation should also include a post-treatment evaluation of the member's response to the treatment or manipulation.

Physical exams When physical exams are performed, document the exams separately from the therapy or manipulation and indicate whether the exam is one of the following:

- Initial examination of a new member or condition;
- Re-examination of a new member within an episode of care to assess member progress, current clinical status, and determine the need for further medically necessary therapeutic level of care; or
- Acute exacerbation of symptoms or significant changes in the member's condition, which are distinctly different indications from original treatment plan.

4.7 DURABLE MEDICAL EQUIPMENT

Introduction Highmark contracted providers are strongly encouraged to refer members to providers participating in the member's network. This includes referrals for durable medical equipment (DME). Reasons for referrals to out-of-network providers should be documented in the medical record.

Highmark Medical Policy Providers are reminded to refer to the pertinent Highmark Medical Policies when referring members for durable medical equipment (DME) or submitting claims for DME.

BOTH the referring physician and the DME supplier are to comply with Highmark Medical Policies (e.g., the supplier should ensure that the referring physician's order is appropriately completed by the physician).

Prescriber The ordering physician must document the member's medical record, at a minimum, with the information below. Additional policy requirements may apply for certain DME.

- Description of DME prescribed
- Length of time DME is indicated for use and updated annually
- Documentation to support why item continues to remain reasonable and customary for ongoing supplies
- Date of face-to-face examination
- Date and results of trial period when required by Medical Policy
- A copy of the prescribing physician's order, including NPI
- Indication of laterality
- Risks and benefits of use

Modifications and customization:

- Documentation within the member's record to list all modifications based on the member's condition.
 - Detailed documentation within the member's record is required to state type of customization needed based on the member's condition.
-

Supplier The DME supplier's documentation must contain, at a minimum, the information below for all billed DME. Additional policy requirements may apply for certain DME.

- Description of DME prescribed
 - Copy of the physician's written order
 - Indication of laterality
 - Indication of trial period, if required (see additional information below)
-

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4.7 DURABLE MEDICAL EQUIPMENT, Continued

Supplier (continued)

- Documentation referencing the actual DME dispensed; the packing slip is to include the following information:
 - Member's name
 - Description of the DME or the full HCPCS description code
 - Quantity
 - Brand name of item
 - Model and serial numbers
 - Date dispensed

Modifications and Customization:

- Documentation within the supplier's records to list all modifications made based on the member's condition.
- Documentation within the supplier's records is required to state how the DME was customized to meet member need as indicated by the prescriber's orders.

Trial periods

Please note that DME suppliers are NOT permitted to have providers and/or members attest that a trial period has occurred. If the supplier is relying on a trial period performed by another provider, the supplier is to document the name of the provider and the dates of service in which the trial period occurred.

If the supplier is unable to discern whether or not a trial period occurred, the DME supplier is required to perform a trial period prior to submitting a claim for a purchase.

Supplier's proof of delivery

Proof of delivery documentation must be maintained in the supplier's records and include the information below:

- Member's name
- Detailed description to sufficiently identify the item(s) being delivered
- Quantity delivered
- Delivery date or shipping date if a delivery service is used (will be the official date of service for the claim)

The member or the member's representative (e.g., relative, neighbor, nursing home, etc.), who does not have a financial interest in the company supplying the prosthetic, must sign to indicate the prosthetic was received.

The member's medical record must include the printed name and signature of the member or the member's designated recipient. If the recipient is someone other than the member, the designated recipient's relationship to the member must also be noted.

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4.7 DURABLE MEDICAL EQUIPMENT, Continued

Refills to the original order

The following apply for refills to the original order:

- Supplier is required to contact the member prior to dispensing the refill to ensure the refill is necessary and document the member requested supplies.
 - Suppliers must have documentation, available upon request, to demonstrate contact with the member to ensure the refill remains reasonable and necessary, existing supplies are approaching exhaustion, and to confirm any changes/modifications to the order prior to delivery or shipment of the product.
 - Contact must be made and documented within the member's record no sooner than two (2) weeks (14 calendar days) prior to the delivery/shipping date.
 - Supplier shall deliver the DME product no sooner than ten (10) calendar days prior to the end of usage for the current product.
 - Suppliers must not dispense a quantity of supplies exceeding the member's expected utilization.
 - Suppliers must stay attuned to changed or unusual utilization patterns; suppliers are required to contact, verify, and document any changes or unusual utilization patterns with the prescribing physician.
-

OBSOLETE

4.7 PROSTHETICS

Introduction

For prosthetics, the expected member functional ability information must be clearly documented and retained in the prosthetist's records and made available upon request.

In addition, the applicable information as outlined below should also be included in the documentation.

Guidelines

The following information must be included within the member's medical record for all prosthetics:

- Member name
 - Member ID number
 - Date of service
 - Member's past history
 - Member's current condition to support the designation of the functional level
 - Member's expected functional capabilities to support the use of modifiers K0-K4
 - Amputation side (laterality) clearly and consistently identified – especially for bilateral members
 - Member's desire to use the new prosthesis, or ambulate (if for lower extremity)
 - Recommendation for the new prosthesis/component(s) and rationale for decision
-

Replacements

If the prosthetic will be a replacement, the status of the current prosthesis/component(s) and reason for replacement must be documented.

In addition, past experience with related items (previous prosthesis/component(s), if pertinent) should be included in the member's medical record.

Relevant physical exams

Any recent physical examinations that are relevant to the member's functional deficits and the need for a prosthetic must be documented in the member's medical records.

The focus is to document body systems impacting the member's functional ability and ambulatory difficulties:

- Weight and height, including recent weight gain or loss
 - Cardiopulmonary examination
 - Musculoskeletal examination
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4.7 PROSTHETICS, Continued

Relevant physical exams
(continued)

- Arm and leg strength and range of motion
- Neurological examination
- Gait
- Balance and coordination

Dispensing prescriptions

When dispensing prescriptions, the following requirements must be met:

- Must comply with all state prescribing and/or other laws.
- A copy of the physician order must be maintained in the medical record and contain a description of the item to be dispensed.
- The provider may write the detailed order; however, the physician must review and sign it.
- Must be dated prior to delivery date.

Microprocessor-controlled prosthetics

Documentation within the member's medical record must show functional need for the technologic or design feature of the microprocessor-controlled prosthetic (e.g., knee).

Customization and modifications

Customization:

- Detailed documentation within the member's record is required to state type of customization needed based on the member's condition.
- Documentation within the supplier's record is required to state how the prosthetic was customized to meet member need as indicated by the prescriber's order.

Modifications:

- Documentation within the member's medical record to list all prescribed modifications based on the member's condition.
- Documentation within the supplier's record to list all modifications included in the prosthetic based on prescriber's orders.

Proof of delivery

Proof of delivery documentation must include the information below and be maintained in the supplier's records:

- Member's name
- Laterality
- Detailed description to sufficiently identify the item(s) being delivered
- Quantity delivered
- Delivery date or shipping date if a delivery service is used (will be the official date of service for the claim)

Continued on next page

4.7 PROSTHETICS, Continued

**Proof of
delivery**
(continued)

The member or the member's representative (e.g., relative, neighbor, nursing home, etc.), who does not have a financial interest in the company supplying the prosthetic, must sign to indicate the prosthetic was received.

The member's medical record must include the printed name and signature of the member or the member's designated recipient. If the recipient is someone other than the member, the designated recipient's relationship to the member must also be noted.

OBSOLETE